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ABSTRACT

This paper documents the development of community mental health (CMH) in New Zealand and makes comparisons with the United States. It is argued that the present New Zealand situation bears some similarity to that existing in the United States during the 1960's. The ideology of 'community mental health' is gaining popularity among professional and lay mental health workers in New Zealand and some hospital boards have, in the past five years, established community-based programs. In contrast to developments in the United States during the 1960's, the translation of CMH concepts into practice has taken place against a background of fiscal stringency and the documented experience of other countries. Examples of the major hospital board CMH projects in New Zealand are given. In contrast to North American CMH centers, New Zealand initiatives provide a narrower range of services, directed toward augmenting and co-ordinating with existing hospital board and primary health care services rather than supplanting them. A feature of the New Zealand situation has been the rapid growth in CMH activities outside of the formal mental health system. Organizations in the voluntary and non-statutory sector have also provided a strong lobby for the provision of more accessible, community-based hospital board services. Ideological, social, financial, and political factors both threatening and facilitating future professional commitment to the CMH field in New Zealand are identified and discussed. (Author/BL)

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THE DEVELOPMENT OF COMMUNITY MENTAL HEALTH SERVICES IN NEW ZEALAND

Paper presented at the Ninety-first Annual
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Division 27, Community Psychology

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ABSTRACT

The movement towards non-hospital based mental health services in New Zealand is described and comparisons are made with community developments in the United States. A distinction is made between the concept of Community Mental Health (CMH) and the shift of mental health personnel to non-hospital settings. Examples of hospital board CMH projects are described to illustrate the translation of concepts into action. CMH activities outside of the professional sphere are also described. Factors both facilitating and threatening future professional commitments to CMH activity in New Zealand are identified and discussed.

PAPER SUMMARY

A shift away from hospital-based mental health services has occurred in a number of countries. The nature and extent of the development of community-based programmes has varied considerably. This paper documents the development of community mental health (CMH) in New Zealand and makes comparisons with the United States. It is argued that the present New Zealand situation bears some similarity to that existing in the United States during the 1960's. The ideology of 'community mental health', is gaining popularity among professional and lay mental health workers in New Zealand and some hospital boards have, in the past five years, established community-based programmes. In contrast to developments in the United States during the 1960s, the translation of CMH concepts into practice has taken place against a background of fiscal stringency and the documented experience of other countries. Examples of the major hospital board CMH projects in New Zealand are given. In contrast to North American CMH centres, New Zealand initiatives provide a narrower range of services, directed toward augmenting and co-ordinating with existing hospital board and primary health care services rather than supplanting them. A feature of the New Zealand situation has been the rapid growth in CMH activities outside of the formal mental health system. Organizations in the voluntary and non statutory sector have also provided a strong lobby for the provision of more accessible, community-based hospital board services. Ideological, social, financial and political factors both threatening and facilitating future professional commitment to the CMH field in New Zealand are identified and discussed.

THE DEVELOPMENT OF COMMUNITY MENTAL HEALTH SERVICES IN NEW ZEALAND

New Zealand, like most other Western industrial states, has in recent years moved toward the provision of mental health services outside of the psychiatric hospital framework.

Dr Clay Rivers presented a paper at the 1981 A.P.A. Annual Convention on New Zealand's mental health services (1). He compared New Zealand with the situation existing in the United States during the 1960's. He considered that 80-90 percent of our mental health services are available through psychiatric hospitals and noted the beginnings of community-based services. He concluded that we were at the crossroads in deciding whether a further broadening of community mental health care is both a desirable and feasible goal.

In this paper I describe some recent initiatives in the community health field and discuss issues which bear directly on the question of future developments in this area. For those unfamiliar with New Zealand, a brief 'national portrait' is provided by way of introduction.

In contrast to Australia, our Pacific neighbour, European settlement of New Zealand from the 1840's was a systematic attempt to export English society to the Antipodes. Demographically, this was achieved. New Zealand, with a land mass slightly greater than the United Kindgdom, has a population of just over 3 million, 90 percent of whom are European, primarily of British descent. While the indigenous population was largely stripped of its land and mana, paternalist and humanitarian values possibly softened the colonization process somewhat. Nevertheless by the early 1900's, land wars, loss of pride and imported disease, had the same effect as the socially if not legally sanctioned genocide policies characteristic of European colonization in some other parts of the world. Today Maoris, the indigenous polynesian race of Aotearoa ("land of the long white cloud"), make up almost 10 percent of the population.

Although New Zealand's economy remains heavily dependent on agriculture, forestry and horticulture, approximately 80 percent of the population

lives in urban areas. The first country to enfranchise women and once considered the 'social laboratory of the world', New Zealand had a reputation as an egalitarian, racially harmonious society with full employment and a well developed social welfare system. While this account no doubt always contained elements of myth alongside reality, tensions are increasingly evident in New Zealand society. There is deep concern, as there is in many countries, about the economy, unemployment, racial conflict, domestic violence, sexual assaults, child abuse and a general sense of erosion of societal and personal stability (2,3,4,5,6). The limited epidemiological data available suggest that, as in other Western countries, 10-15 percent of the population have clinically significant psychological problems at any given time. Women with pre-school children, unemployed people, the poor, the aged, and ethnic minorities appear to be most at risk.

Increased awareness of these problems by health professionals and members of the general public, combined with the recognition that hospital-based clinical services at their best could ever only effectively deal with a small proportion of the most severe cases, has probably provided part of the push towards community-based services. Formal inquiries into the quality of care provided in some of our hospitals has raised serious questions regarding their appropriateness as the main locus of treatment (7). The concern to prevent psychological problems from arising and to intervene early in their development has also increased interest in the broader community mental health focus. As in other countries, the rise of 'consumerism', self-help groups and a view of health that transcends the absence of illness, has added to social demands for accessible mental health services which include educational, consultative and preventive components. Policy makers have become aware of the prohibitive cost of traditional institutional services and have put pressure on hospitals to reduce bed numbers. Health professionals point out that substantial reductions have already been made and argue that to go further, and maintain in the community those already discharged, community-based centres will be necessary. Concern has also been expressed that if we fail to provide a continuity of service, we will repeat the errors made in some North American cities. Others have maintained that the general public is not adequately prepared to cope with many of the patients currently resident in our psychiatric hospitals and that greater

effort must be put into public education and attitude change (8,9). It is against this background that Hospital Boards (which are currently responsible for the administration of psychiatric hospitals and services) have started to develop community-based mental health services.[1]

In the United States, where the movement of mental health services to the community is perhaps most evident (and certainly most documented), this change was in large part a direct consequence of Federal legislation and the targeting of central government funds to training programmes and new mental health centres which conformed to specific criteria.

(Kennedy's) Community Mental Health Act was passed in 1963 and called for the establishment of comprehensive CMH and Mental retardation centres. These were to be located in the community (i.e. separate from psychiatric and general hospitals) and to serve maximum populations of 200,000. They were also to develop modes of service delivery that would maximize availability to every member of the population group.

To qualify for support under this act, CMH, had to provide 5 basic services:

1. In-patient care
2. Out-patient care
3. Partial hospitalization
4. Twenty-four hour emergency services
5. Consultation and education offered to the community.

They were also required to involve non mental health professionals (from the 'community') in the planning and delivery of services.

Of the 2,000 centres envisaged, approximately 500 eventuated. Some have since closed with the financial belt tightening which has hit both hospitals and community centres.

For a variety of reasons, relating in part to the background and training of staff and to community demands for clinical services, many of these centres became, in effect, mini hospitals (old wine in new jars). Some established new forms of service including the involvement of volunteers,

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1. There is only one small private mental hospital in New Zealand and most psychiatrists and clinical psychologists are employed by Hospital Boards.

lay counsellors, and other community agencies. More people were treated, but little was done in the area of prevention, especially primary prevention. In some areas there was a neglect of the more severely disabled schizophrenic patients. In some States, patients discharged from closed hospital wards ended up living in destitute situations, while others provided a new source of input to the prisons.

It would seem that the centres tend to focus on the 'middle ground', providing more extensive clinical coverage for the moderately disturbed, but relatively little for the severe psychiatric disorders and less in the area of prevention.

Nationwide, it was found that only 5 percent of CMH Centre staff resources were devoted to consultation and education. And of this, only a fraction went into primary prevention. Much of it went to public relations, case-finding and education. 'Prevention' was often used in a vague way to give respectability to a range of activities with little relevance to the reduction in rates of psychological disorder (10).

Although the impression is often given that the U.S. has moved from a hospital to a community-centred system of service delivery, this is misleading. Even in the boom period of CMH Centre growth (1964-68) Federal expenditure for CMH Centres was less than 5 percent of the expenditure for state mental hospitals.

In New Zealand, there has been a gradual movement towards community outreach from our hospital based system. This has ranged from out-patient services in psychiatric and general hospitals, to the development of domicilary and rehabilitation services with ex-patients living in hospital-owned or rented houses.[1] Our cities have sprawled outward to engulf the previously distant asylums, and the high walls and fences have come down. Child health clinics, with a large mental health component, were perhaps our first move toward free-standing centres for salaried mental health workers.[2] In the main, these developments were an extension of clinical services rather than a departure into new roles and professional activities.

There has also been an increased concern for the mental health aspect of health care for primary health care workers.[3] There is a move towards wider

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1. See Appendix 1
2. See Appendix 2
3. See Appendix 3

community involvement here too. As in the United Kingdom, G.P.s probably continue to be the main, or at least the first, point of contact for people experiencing psychological distress (11). However, this group, as well as mental health professionals in private practice, are not usually included within definitions of community mental health.

Table 1
about here

In 1977, we had our homegrown 'equivalent' of the U.S. CMHC Act in the form of a Budget Night announcement of increased duty on tobacco and alcohol, to provide additional revenue for the extension of community health activities. Not quite in the same league as a Presidential address to Congress on the mental health needs of the nation but in its own way, this provided the central government push which opened the way to further expand community health, including mental health services within hospital boards.

To qualify for funding, a project was required to:

1. Obviate the need for hospital admission;
2. Assist early patient discharge;
3. Promote health and prevent illness.

In some Boards, additional staff were funded to extend community services from already existing units or hospitals. One of the larger examples of this type was in Nelson, a programme for children with special needs attached to a Child and Family Clinic.Six hospital-aide salaries were divided to provide remuneration to 40 or more home/community aides. These people worked in close association with the professional team to provide support and therapeutic activities for pre-school and school-age children under stress or evidencing behaviour problems. Dr Kay Bradford says that "like any imaginative aunt or uncle, they work with the children in a wide range of locations - their own homes, other people's homes, our community hall, the Neighbourhood Centre, picnic places, the seashore, the art gallery, and so on". She claims that the programme has led to a reduction in admissions to the local paediatric hospital and that many more families and

children are being helped than before with no increase in professional staff.

Other Boards took the opportunity to establish new services, located in community settings. Among these, we find the closest parallels to CMH Centres as they exist in the United States.

Table 2
about here

Ponsonby Care, unlike the other centres, was set up specifically to focus on aftercare for discharged psychiatric patients, especially schizophrenics. This was an attempt to break the discharge - stress - relapse readmission cycle (the revolving door) by providing a drop-in centre, counselling, supervision of medication, advocacy, and a regular activity programme.

In terms of location, Ponsonby Care is perhaps our closest equivalent, of the Hospital Board Centres, to the so-called store front clinics of the North American scene. It is located in the central city area of Auckland - a part of the city with a large population of ex-psychiatric patients living in boarding houses and flats. However this is a rapidly changing district. There has been a rapid influx of young professionals seeking 'trendy' inner city life styles. House prices have escalated and cheap accommodation diminished. These changes are reflected in shifts in the sociodemographic 'mix' of the area. The chronic schizophrenics and ethnic minorities are being squeezed out. Although large numbers of ex-hospital patients still use the centre, it has taken on additional functions reflecting the changing needs (or demands) in the surrounding neighbourhood. Ponsonby Care now provides a pychological assessment service for local social service agencies and General Practitioners.

All of the Auckland community mental health centres are linked administratively with Carrington Hospital. The other Auckland centres and Hillview in the Hutt Valley offer a wide range of services consistent with community mental health models. They operate from freestanding buildings previously built for other purposes, in residential areas. The staffing patterns of the Auckland centres are given in Table 3.

While the main focus of professional staff involvement is on traditional clinical activities, namely clinical assessment and counselling/therapy, the emphasis is more likely to be on family therapy and/or group therapy, social skills training, and other group activities.

These centres also have extensive networks of volunteer workers with paid community worker co-ordinators. Typically, the community workers have come from the ranks of the volunteers and are not trained health professionals. Volunteers play a variety of roles, a major one being to provide 'low key' support to individuals and families under stress. Through their involvement in early intervention, they may well play a part in preventing more serious disturbance arising. They also refer people to, and take referrals from, centre professionals.

Professionals are also involved in co-ordination, consultation and education within their 'catchment' areas. The centres link with a wide variety of local organizations - supporting mental health aspects of their work. To varying degrees, they provide an assessment and therapy/support backup for primary health care professionals including General Practitioners. In the case of Pentlands, over sixty percent of referrals in 1981 came from local G.P.s. While a major concern is to arrange support and provide therapy to distressed individuals near to their place of residence, referrals are made to psychiatric hospitals. Followup support for discharged patients is also provided to some degree. It is claimed by staff at Mt Albert that they have managed to considerably reduce the number of new admissions from their area to Carrington. They claim to have done less well in reducing readmissions of previous hospital patients.

The New Zealand community mental health centres and the smaller family health counselling centres found in some Board areas,[1] attempt to complement existing services. They don't have inpatients, they don't usually take day patients on a regular basis and they do not provide 24-hour crisis cover. While workers in the centres report pressure from various sources to function as hospital outpatient clinics, they attempt to work toward providing a continuum of care or service - filling some of the 'gaps' (or perhaps more correctly, chasms) previously existing between the family or the neighbourhood and the large psychiatric hospital.

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1. See Appendix 4.

Thus, in themselves, the centres are less comprehensive than their U.S. counterparts. Although I have no firm data to back up this contention, it would seem that as in the U.S., consultation and prevention (especially primary prevention) have suffered because of clinical demands. The major exception is the North Canterbury Community Mental Health Service.[1] In this country, this team is unique in that it offers no direct patient services but functions exclusively in the areas of consultation, education, co-ordination and prevention.

While I have focussed on community developments within hospital boards, much more activity and innovation in the broad community mental health field has taken place outside of the health services. This is evident in the increased awareness of community mental health and community development concepts in various Government Departments (e.g. Social Welfare, Justice, Internal Affairs, Maori Affairs and perhaps to a lesser extent, Education) and in changes in staff activities consistent with the shift in attitude. Perhaps more dramatic has been the rapid and substantial growth in voluntary and self-help groups/organizations concerned with mental health. Some, e.g. Schizophrenia Fellowship, Huntington's Support Group and GROW, have a focus on more severe disorders. Groups such as parents centres, the Widows and Widowers Association, agoraphobia support groups, Gamblers' Anonymous and postnatal support groups, are examples of the many supportive networks and self-help programmes that now exist in our larger towns and cities. Telephone counselling by skilled lay people has become popular and grown from the crisis counselling of Lifeline to include the more specialized services of Youthline, Gayline, Parentline, and most recently in Christchurch, Childhelpline.

More established welfare and helping agencies (e.g. church social services, YWCA, Marriage Guidance) have shifted from giving practical aid or counselling to include outreach activities, community liaison, and education. Technical Institutes, Community Colleges, University Extension departments, and less formal agencies involved in adult and community education, have become increasingly involved in running courses on coping skills, e.g. assertiveness training, parent effectiveness training, communication skills, and stress management courses. Some city councils have employed community workers and supported the development of community houses, drop-in centres, and creches.

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1. See Appendix 5.

Private companies have employed health workers, e.g. occupational nurses and industrial chaplains. Some organizations have set up early intervention programmes (e.g. alcohol in industry programmes promoted by the Alcoholic Advisory Council) and run courses on communication skills and stress management. Thus, much of what we could consider to be the mental health counterpart of public health medicine has occurred in these areas. While it would not be appropriate, or possible, for Hospital Board professionals to assume these varied roles, many people active in the community do feel the need for more adequate liaison, professional backup, and in some instances, consultation and assistance with training. Here there is an important need for greater understanding between mental health professionals and community workers and volunteers, and closer working relationships. The partial transfer of responsibility to the community needs to be matched not only with better professional backup and support - it also requires more adequate funding and recognition by officials and health professionals.

What is the future of community mental health in our hospital board services?

At the level of national government there is a strong ideological commitment to further community development. Statements from the present government's 1981 election manifesto included an undertaking to:

- "promote health education and further expand occupational health services....";
- "place more emphasis on educational, community and preventive aspects of health care, rather than the institutional, restorative and curative .....";
- "continue to encourage and assist hospital boards to extend their community health and home care services ...".

The other two major political parties similarly emphasized community care and a concern with prevention and early intervention.

The Planning Council, a central government advisory body, has also argued for an increase in resources in these areas. Reports from two pilot schemes (Wellington and Northland) examining the Health Board concept have reflected the sentiments expressed at the national level.

It is likely that any sizeable increase and/or shift of resources to a community-based system of mental health care will require a firm push from

central government. Evidence for this comes from other countries where attempts have been made to establish comprehensive community mental health services. As already noted, the major thrust in New Zealand came with the "Beer and Baccy tax" and the Community Health Care Grant through the Department of Health.

While ideological commitment is necessary, so too is a comprehensive policy and a funding and administrative apparatus to put it into operation. It would seem that a backward step has occurred in this respect. Since April 1, 1982, the money for community projects was no longer 'tagged'. It became part of the general allocation made to hospital boards. While this is consistent with Treasury's dislike of separate accounts and the Government's commitment to local decision-making regarding the allocation of resources, the move may carry with it grave consequences. While local decision-making sounds fine in principle, it is important to appreciate who the decision-makers are in this instance. There are indications that consultants in clinical medical specialties and professional administrators have a major say in hospital board politics. In the scramble for scarce resources, psychiatry almost invariably emerges as the poor relative. And within the mental health domain, psychiatrists tend to be hospital and treatment-oriented. Professionals with a community mental health orientation typically have little input into the decision-making process and there is even less room for non-hospital board community agencies and workers to have their views heard and responded to. While this is the way things tend to be, it is not written in concrete. Our hospital boards are comprised of elected representatives. Active lobbying of existing members and efforts to have community-oriented people elected are available strategies for those interested in change and are being pursued in some parts of the country.

At the moment, the 1969 Mental Health Act is under review by the Health Department. Submissions from community groups and professionals have been requested. Legislation emerging from this review could play an important part in shaping the future direction of our mental health services.

In Italy, a review of that country's mental health legislation and psychiatric practice led to a ruling that no more patients were to be admitted to state psychiatric hospitals. While such a radical rethinking is unlikely to emerge out of local deliberations, it is possible that changes to legislation will

have implications for the way mental health services are delivered (12).

A major barrier to change at the hospital board level is that relative to many other Western industrial states, our current clinical and hospital services are understaffed. Many psychiatric clinicians in senior decision-making positions appear reluctant to have staff deployed in non-traditional settings when they consider that they are barely coping with present case-loads. There also appears to be a widespread belief that the population of readily dischargeable hospital patients has 'bottomed out' - i.e. the majority of long-stay patients who can be rehabilitated have already been discharged and although fewer first admissions today become 'chronic' hospital residents, there has nevertheless developed a quite sizable residual group of so-called 'new long-stay patients'. It can be argued that the short-term prospects for effective primary prevention with this group do not look good. Here I am speaking particularly of the more deteriorated schizophrenics, elderly people with senile and artherosclerotic dementias, and others with severe brain damage. While active policies to reduce motor vehicle accidents and the level of alcohol consumption could reduce numbers in the latter category, this does nothing to help the large numbers of such people existing <u>now</u> (13). Treatment prospects are poor and unless there is a considerable shift in community attitudes and a very large increase in alternative structured settings, these people will continue to require hospital care.

These issues cannot be ignored. However, they do not provide sufficient reason to halt the development of more adequate services for the majority of disturbed and distressed people in our communities. For some of these people, preventive strategies could have been effective if they were operating. For others, early intervention from accessible community-based centres could stop more severe disability from developing and alleviate current suffering. In addition, adequate community support from lay people and professionals is necessary if we are to keep in the community people who have been discharged or rehabilitated from psychiatric inpatient care.

While the literature is relatively thin in this area of prevention, and especially primary prevention, there are a number of published studies demonstrating that when carefully tailored interventions are directed toward high risk groups to achieve specific goals, positive outcomes do occur (14). Where the intervention is more diffuse and the group less specifically targeted,

it is more difficult to establish that prevention has occurred (15). However, this may be as much a reflection on our research methodology as an indication of weak intervention effects.

While there are local clinicians and administrators who damn community alternatives and call for outcome evaluations. There are others who point out that these people apply far less rigorous tests to their own (hospital-based) activities. The assumption is often made that existing clinical services are effective and meet patient needs.

Ideally, rational service development should be based on outcome and cost benefit analyses. Such work is in its infancy in New Zealand. However, those advocating community-based services can be heartened by Kiesler's recent review of the relevant literature (16).

Kiesler located 10 studies where severely disturbed psychiatric patients had been randomly allocated to psychiatric hospitals and non-hospital based programmes. He concluded from this review that:

(1) A variety of forms of alternate care were as good as (and usually better than) quality hospital treatment;

(2) Psychiatric hospitalization was self perpetuating (even when the emphasis was on brief in-patient stays);

(3) In the U.S., even at a time when policy had shifted toward non-hospital alternatives, too many people were being hospitalized;

(4) Effective non-institutional interventions were active modes of care (emphasizing behavioural skill building, social systems interventions and basic support) that require skilled professional input; and

(5) In no instances were alternate methods of care more expensive than hospitalization. They were often considerably less expensive.

In the United States, psychiatrists played an important part in the community mental health movement. Dr Rivers observed that New Zealand has few senior psychiatrists with a social psychiatry orientation and a large number who emphasize organic issues and traditional treatment modes. He believed few were equipped by training or philosophy to act as leaders in promoting comprehensive mental health services embracing community and hospital settings

and that while a slightly larger percentage of non-psychiatrist mental health professionals may have a community orientation, they rarely have the power to produce major structural changes. I have some sympathy for the view that psychiatric domination combined with conceptual impoverishment is a barrier to community developments in this country. Some psychiatrists, understandably, don't go along with me here (For example see Abbott, 1983 (17)).

However, lack of adequate professional preparation for community-based practice and roles in prevention, consultation, co-ordination, advocacy and community education is not confined to psychiatry but extends to clinical psychology and other health professions. Changes in professional training are required if we are to provide a spectrum of services and not simply transfer traditional modes of practice to new settings.

Related to the earlier mention of changes in the administration of the Community Health Care Fund is the fact that the major decision-making bodies in this country are hospital boards. These are hospital boards - not health boards, and not mental health boards. The primary concern is with hospitals, with clinical services, and with physical health (or more correctly ill health). It is a long haul to have community mental health concepts translated into practice. In addition, the journey does not have to be made once - it has to be made twenty-nine times. (The number of hospital boards in New Zealand)! This is the main reason why direction from central government may be necessary to achieve widespread change.

There are barriers. There are also positive signs. Support appears to be widespread for more accessible mental health services and for more emphasis on prevention, at both the national and local level (18). In part the concern is humanitarian, in part financial. Hospital care for the severely disabled is expensive. There are a number of community mental health centres currently operating and people in areas which lack these services are beginning to push for similar developments in their communities. Recently I have had contact with well-organized groups in Palmerston North, Hamilton and South Auckland - groups actively lobbying for changes in hospital board provision while taking the initiative of setting up supportive networks and community mental health projects on their own behalf.

The Health Department reviewed community health projects early this year. None of the predominantly mental health projects have, to date, been closed down as a result of this review or the transfer of previously targeted funds to general hospital board allocations.

A major reorganization of New Zealand's health services has been proposed by the Minister (19,20). Health boards will replace hospital boards as the major service planning and administrative unit. While money will not be directed to community mental health projects from Central Government, rumour has it that boards will be required to allocate approximately 20 percent of their funds to mental health services. In some areas, this would provide a much larger 'slice of the cake' for mental health. Service planning guidelines are currently being prepared by the Health Department. While these will not be binding on hospital boards or health boards (which will be phased in over a number of years) they are likely to provide prescriptive directions on the matter of community services. The planning structure for Health Boards, at the regional level, requires consultation with voluntary and non hospital agencies. Consequently, there is a greater likelihood that local community-oriented views will impact on the decision-making process. It remains to be seen whether these proposed changes will stimulate further development of community mental health services in New Zealand. Commitment and organization on the part of local citizens could be expected to be an important factor.

REFERENCES

1. Rivers, C. Community Mental Health in New Zealand. paper presented at the American Psychological Association Annual Convention, 1981.

2. Abbott, M.W. (Ed) Mental Health Foundation of New Zealand - New Zealand Psychological Society Symposium on Unemployment : Papers and Reports. Mental Health Foundation of New Zealand, Auckland, 1982.

3. Submissions from the Mental Health Foundation to the Medical Research Council's Review Panel on Epidemiological Research. Mental Health Foundation of New Zealand, Auckland, July 1983.

4. Abbott, M.W. (Ed) Postnatal Depression, Mental Health Foundation of New Zealand, Auckland, 1982.

5. Haines, H. and Abbott, M.W. (Ed) Proceedings of the National Seminar on Rape, Wellington, September 1982. Mental Health Foundation of New Zealand, 1983.

6. A socio-economic assessment of New Zealand women's refuges. Synergy Applied Research Limited, Wellington, March 1983.

7. Report of the Committee of Inquiry into procedures at Oakley Hospital and related matters. Government Printer, Wellington, 1983.

8. Walkey, F.H., Green, D.E., and Taylor, A.J.W. Community attidues to mental health : a comparative study. Social Science Medicine, 15, 139-144. 1981.

9. Blizard, P.J. Public images of the mentally ill in New Zealand. N.Z. Medical Journal, 68, 297, 1968.

10. Klein, D.C. and Goldston, S.E. Primary Prevention : An idea whose time has come. National Institute of Mental Health, DHHS Publication No.(ADM) 80-447, 1977.

11. Attitude to and Experience of Mental Illhealth : a Segmentation Study of the New Zealand Population. Heylen Research Centre, Auckland, 1977.

12. Comments of the task force upon the Departmental Position Paper of 28 February 1983 re. review of the Mental Health Act 1969. Mental Health Foundation of New Zealand, Auckland, 1983.

13. Abbott, M.W. The early diagnosis of alcohol-related brain damage. In press, Journal of the New Zealand Medical Society on Alcohol and Alcoholism.

14. American Journal of Community Psychology,(Special Edition on Prevention) 10, (3), 239-367, 1982.

15. Raphael, B. Primary prevention : fact or fiction, Aust. and N.Z. Journal of Psychiatry, 14, 163-174, 1980.

16. Kiesler, C.A. Mental hospitals and alternative care : Noninstitutionalization as potential public policy for mental patients. American Psychologist, 37, (4), 349-360, 1982.

References cont...

17. Abbott, M.W. (Ed) Community Mental Health in New Zealand : Report and reactions. Mental Health Foundation of New Zealand, Auckland, 1983.

18. Abbott, M.W. (Ed) Child Abuse Prevention in New Zealand. Mental Health Foundation of New Zealand, Auckland, 1983.

19. Health Services Reorganization : A Discussion Document. Department of Health, Wellington, 1982.

20. Whole edition, New Zealand Health Review, 1983, 3 (2).

TABLE 1

HOSPITAL BOARD 'COMMUNITY' MENTAL HEALTH SERVICES

Psychiatric outpatient services

- psychiatric hospitals
- psychiatric wards, general hospitals
- social work departments
- psychology departments

Psychiatric hospitals - houses for ex-patients domiciliary psychiatric nurses/social workers/occupational therapists

Child Health Clinics

Community Mental Health Centres/'Houses'

Family Health Counselling Centres

PRIMARY HEALTH CARE

Plunket
- houses/support centres
- plunket aides/helpers

Social Workers/Practice Nurses attached to G.P.s.

Public Health Nurses/District Nurses

Psychiatrists/Psychologists/Counsellors in private practice.

TABLE 2

FUNDED BY DEPARTMENT OF HEALTH COMMUNITY CARE GRANT

Mt Albert Centre for Community Health Care
Ponsonby Care Centre
Henderson House
Pentlands [a]
} Auckland

Programme for Children with Special Needs, Nelson

Hillview - Hutt Regional Community Mental Health Services

Community Mental Health Service, Christchurch

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a Started before 1977 (1975) as a day hospital

TABLE 3

STAFFING PATTERNS[a]
CARRINGTON COMMUNITY MENTAL HEALTH CENTRES

	Pentlands (May 1981)	Mt Albert (1981)	Ponsonby Care (1982)	Henderson House (1982)
Project Officer	1	1		1
Psychiatrists	5/10	5/10	2/10	5/10
Psychologists	1	9/10		1
Social Workers	1	8/10	1	
Nurses	3	3	4	2
Occupational Therapists (+Aides)	1	6/10	2	7/10
Receptionists	1	1		1
Volunteer Co-ordinators	1	2	1	2 5/10
Volunteers	40-60	60	60	110

a Fulltime equivalents

APPENDIX 1

DOMICILIARY NURSING SERVICE

Edwin Hall Clinic
Sunnyside Hospital
Christchurch.

Telephone: 381-740

Background

Concern expressed by nursing staff over the lack of adequate follow-up in the community of patients discharged from Sunnyside Hospital, led to the formation in 1967 of the Sunnyside Domiciliary Nursing Service. In 1972, the first group home, aimed at locating long term patients back into the community, was established. By the end of 1982, thirty such group homes were operating, along with three boarding houses catering for Sunnyside outpatients.

Objectives

The service aims to assist patients discharged or on trial leave from Sunnyside Hospital to regain and maintain a satisfactory level of health, particularly mental health, so that the need for readmission will be prevented or reduced.

Organisation

The service operates out of the Edwin Hall Clinic of Sunnyside Hospital. Staff are co-ordinated by a Community Services Supervisor. In general, the domiciliary nurses work alone with their case loads. After the decision is made by the ward team that domiciliary care by nurses is necessary, it is left to the nurse to determine management geared to individual patient needs.

Staff

Seventeen full-time registered psychiatric nurses and one hospital aide are involved with the service, along with a half-time social worker and a half-time occupational therapist. Two doctors are available when required. Between 12 to 15 volunteers belong to three support groups, co-ordinated by the Support Group Committee. They help patients in the group homes to set up house and to become integrated into the community, by providing neighbourly support.

Users

Approximately 700 patients are being visited by domiciliary nurses. Most nurses have a case load of about 50 patients. Almost all patients are seen regularly (i.e., at least monthly). A patient's family and friends are involved in the nurse's care of him or her. People have learnt about the service from general practitioners, social workers, ministers of religion and by word of mouth. However, all patients must be referred by Sunnyside Hospital (e.g., Fergusson Clinic or the Edwin Hall Assessment Team).

Comment

The Domiciliary Nursing Service is meeting an obvious need. Beginning with one nurse in 1967, it has grown into a well organised service. Until recently a somewhat closed unit, the service is now making greater contact with other caring services and more sharing of information is taking place. Its group homes make it possible for people to live in the community who would otherwise be in institutions. Impressions of patients living in these homes and of the people giving them support are sought, and any necessary adjustments are made. Staff are able to voice their opinions at daily (or in the case of the half-time staff, weekly) staff meetings.

Access

Only through Sunnyside Hospital.

APPENDIX 2

CHILD AND FAMILY GUIDANCE CENTRE

Whakatata House
Cnr Cashel and Montreal Streets
Christchurch

Telephone: 62-325

Background

The Child and Family Guidance Centre was established by the North Canterbury Hospital Board in Whakatata House in 1979.

Objectives

The aims of the Centre are:

1. To provide outpatient assessment and treatment services for children up to the age of 16 years and their families where the children are experiencing difficulty in development, behaviour, in emotional adjustment, or where the family as a whole is experiencing conflict and difficulty which is affect ng the children.
2. To collaborate with other agencies associated with the child and family in order to provide a co-ordinated programme of help.
3. To contribute to the training of professionals in various disciplines.
4. To run seminars, lectures, etc., for people working with children and families and for parents.
5. To provide shortly a day treatment service for pre-school children and their families.

The assessment procedure involves observing and understanding the child or his behaviour in the context of the family unit and assisting families to find new solutions to old problems. A variety of therapeutic techniques are available, including family therapy, individual psychotherapy, behaviour modification techniques, group therapies and home support.

Organisation

The Child and Family Guidance Centre is a section of psychological medicine services of the North Canterbury Hospital Board. The director is responsible for the day-to-day running of the Centre. The running costs of the Centre are jointly met by the North Canterbury Hospital Board and Community Health Care funding.

Staff

There are 16 full-time, 5 visiting and 2 registrar positions at the Centre. Staff are professionals in the following fields: child psychiatry, general psychiatry, clinical psychology, educational psychology, child psychotherapy, paediatrics, social work and office work. From 10 to 12 volunteers are involved with the work of the Centre. Their role is largely one of supplying support, under supervision, to families with severe parenting difficulties through home visiting, being an after-hours telephone contact, and by participating in group therapies for children and parents together with the paid staff at the Centre. Some volunteers are trained to do more specific tasks under supervision with young children. The Centre provides in-service training and supervision for volunteers, who sometimes do ancillary courses in social skills and social work at the Christchurch Polytechnic. They are co-ordinated by a social worker.

Users

In 1981 there were 573 new family group referrals. At any one time the Centre has 440 on-going cases. Families can be referred to the Centre by medical practitioners and other health professionals, social service agencies, the Psychological Service and lawyers.

Comment

The Child and Family Guidance Centre is the only service of its kind in the region. It is able to offer training opportunities to staff in a variety of disciplines related to working with children and families. No survey of users' views has been carried out, but the perceived opinions of users are taken into account providing these do not conflict with the therapeutic goals and standards of the Centre. Staff participate in the decision-making process at full staff meetings and at small administrative group meetings.

Future

In spite of expansion during recent years, the Centre is unable to provide the level of service thought necessary on a population basis (i.e., 1% instead of the approximately 0.5% of the child population currently being seen per annum). The Centre hopes to be able to provide this level of coverage eventually. The facilities for the day treatment service for pre-school children have been completed but a staff grant is required before this extension to the work of the Child and Family Guidance Centre can become operational.

Access

Through health, education, legal and helping professionals.

APPENDIX 3

PRIMARY HEALTH CARE SOCIAL WORKERS

Papanui Medical Centre
438 Papanui Road
Christchurch.

Telephone: 529-053

Hoon Hay Medical Centre
124 Sparks Road
Christchurch.

Telephone: 388-179

Background

By May 1978, ministerial approval had been obtained for the involvement of hospital social workers in the development of primary health care projects in the community on a limited trial basis. As a result, a social worker was based at the Papanui Medical Centre (this followed the involvement of local doctors and social workers in the development of the project). After a detailed assessment of interested practices in a number of areas, a social worker was based at the Hoon Hay Medical Centre in February 1981.

Objectives

The main aims are to enable the Centres' doctors to more fully understand the patients' backgrounds and thus help patients deal with social factors, to provide improved counselling facilities (allowing more time for casework), and to provide better communication between the medical centres and other agencies.

Organisation

The medical centres and the Hospital Board jointly administer the service with the Board responsible for funding and running costs (each year this amounts to about $25,000 for each practice). The day-to-day running of the service is undertaken by the social worker, who is available from 8.30 a.m. to 5.00 p.m., and on call through the doctor on duty. There is no charge to users.

Users

People using the service must be patients of a doctor at the medical centre. Most people seen by the social workers have social difficulties and/or problems related to stress. A proportion of each social workers' time is taken up with work in, or liaison with, groups in the community. At Papanui, an average of 200 families use the service each year, with up to 50 new patients attending each month. At Hoon Hay, 30 new patients are seen on average each month, with over 360 families using the service each year.

Comment

The social workers and doctors have found the service is in constant demand and that client satisfaction is apparent. Evaluation, by the Hospital Board and the Department of Health, has been carried out to assess the effectiveness of the service in terms of finance and resources.

Access

Available (only to patients of doctors at the medical centre) through a doctor or direct to the social worker.

Note: At Christchurch South Health Centre (163 Colombo Street, Telephone 34-108) a trained social worker is employed on a full-time basis to provide a counselling and back-up service for patients of the practice.

APPENDIX 4

FAMILY HEALTH COUNSELLING CENTRE

41 Harewood Road
Christchurch.

P O Box 20-109
Christchurch.

Telephone: 526-181

Background

The Bishopdale Family Health Counselling Centre was established in 1978 and sited in the Bishopdale Community Centre. The Centre was established after consultation with community, welfare and social service agencies, general practitioners and local voluntary organisations. A thorough survey and consultation programme was entered into by the North Canterbury Hospital Board before the Centre was established. Recently, the Centre has relocated to an older style house in Harewood Road and staff work with the mixture of small communities within the north west of Christchurch.

Objectives

"The Centre's focus is on the family and its place within the community, but the approach is also directed towards the community as a whole". The programmes aim to emphasise the value of positive health skills and attitudes and acknowledge that healthy people can be strengthened by learning to deal with problems in a positive manner."

Staff

Full time staff include a psychologist, social worker, senior social worker and a secretary/typist.

Organisation

The Centre is funded and administered by the North Canterbury Hospital Board through its Community Health Care Services. There is no charge to users. The Centre provides a free service for family counselling and consultation, family health education and community development. The programme is aimed at improving standards of family health and is complementary to other medical, statutory and voluntary health and welfare agencies.

Users

During the 1981/82 financial year, people used the service on 3973 occasions. Most local doctors frequently refer people for counselling. These referrals have increased over the past years and are now the single largest source of referrals although an open door, drop-in policy is maintained and of late, the number of self-referrals has increased. The majority of users are experiencing problems with parenting and child management, marital or relationship difficulties, anxiety or depression. The Centre does not see itself as involved in long-term counselling and support services, but will involve other people and refer clients on if and when needed.

Comment

With the move into the Papanui area, the Centre is dealing with a different section of the community. Staff remain concerned about the effects of unemployment and in particular, the plight of young school leavers who are leaving school without employment prospects. It is planned to investigate this most important area in the future, and the staff believes that some commitment at a local level may play an important preventive role in relation to health care. The Centre feels it succeeds because it is able to offer a free, open, accessible, immediate and confidential service. It provides a unique service within the local community and is meeting an important need in the north west of Christchurch.

Access

Self-referrals welcome and encouraged.

APPENDIX 5

COMMUNITY MENTAL HEALTH TEAM

Old Registry Building
The Arts Centre
301 Montreal Street
Christchurch

P O Box 845
Christchurch

Telephone: 792-934

Background

From 1972 the Working Party on Community Mental Health of the Psychiatric Advisory Committee of the North Canterbury Hospital Board had been involved in devising approaches for the provision of Community Mental Health Services compatible with other developments in Mental Health Services to meet Christchurch urban area needs. In June 1977, the Working Party sponsored a workshop on Community Mental Health, which was attended by 130 people representing over 40 agencies. It was decided that professional mental health staff should be employed to support and foster existing, developing and potential volunteer groups rather than extend direct care services as this could duplicate the efforts of the existing network of health and voluntary community agencies. It was special funds made available by the Minister of Health that made the service possible and stimulated the workshop.

Objectives

The objectives of the service have remained unchanged throughout its development. They are:

- to encourage and support existing community development activities sponsored by local government and other agencies;
- to improve the collaboration between health and social service professionals at the neighbourhood level; and
- to provide a mental health consultative service to individual professionals or agencies and educative and preventive programmes to the community.

The activities of the Community Mental Health Team fall within three broad categories: consultation, co-ordination and education. The Team has established a consultative relationship with professional agencies, particularly those dealing with "at risk" groups, community groups and mutual aid groups. It has initiated or given support to a number of meetings which have brought together agencies in the same field and thus promoted co-operation between them and a better utilization of resources. It has run educational sessions which range from small group presentations on requested topics, such as stress, post-natal depression or personality disorders; to major seminars and courses which have at times been co-sponsored by other agencies.

Organisation

The day-to-day administration of the service is the responsibility of the Community Mental Health Adviser, who filfuls the role of team leader. He is assisted by a secretary. Staff meetings are held weekly, at which requests received for the Team's assistance are considered. Policy decisions, priorities of work and responses to requests are made jointly by members of the Team. The Community Mental Health Service office is open from 8.30 a.m. to 5.00 p.m. weekdays.

The work of the Team is funded by the Health Department and administered by the North Canterbury Hospital Board.

Staff

The Community Mental Health Team consists of one adviser, one psychiatric nurse, one social worker, one secretary, one part-time psychiatrist, one part-time psychologist, one part-time occupational therapist and one part-time research and evaluation officer.

Users

The Community Mental Health Team has had contact with a wide variety and large number of organisations. During the twelve months ending 30 September 1981, 4495 people attended education sessions conducted by members of the Team. The service has published pamphlets on such topics as Grief, Coping with Life Events, Self Esteem and Community Involvement, which are made available to both groups and individuals.

Comment

The Community Mental Health Team is seen as innovative in the New Zealand mental health scene, by being the only team of hospital board mental health professionals in the country without clinical duties and with a focus on prevention, co-ordination, consultation and advocacy. This service has been looked to as a model for development of similar services in other regions of the country. The involvement of the community through all stages of its development has led to an awareness of community needs. The multi-disciplinary nature of the Team has provided a wide base for professional resources which strive to meet consumer needs. The positive response received from agencies with which the Team has been in contact testifies to the value of its input. The Team's work has been subjected to regular and on-going evaluation, which it has found to be a useful discipline.

Access

Self-referral for agencies.